FOREWORD

Medicare Reform and the Change from HCFA to CMS
During the first wave of reforms designed to strengthen the healthcare services and information available to nearly 70 million Medicare and Medicaid beneficiaries and the providers who serve them, the Health Care Financing Administration (HCFA) was renamed the Centers for Medicare & Medicaid Services (CMS) in June 2001. The name change marks the first of many steps being taken to become a more responsive and effective Agency that is refocused along its three primary lines of service:

- **The Center for Medicare Management** - focuses on management of traditional fee-for-service Medicare to include development of payment policy and management of the Medicare fee-for-service contractors;
- **The Center for Beneficiary Choices** - focuses on providing beneficiaries with information on Medicare, Medicare Select, Medicare Advantage, and Medigap options to include management of the Medicare Advantage plans, consumer research and demonstrations, and grievance and appeals functions; and
- **The Center for Medicaid and State Operations** - focuses on programs administered by states to include Medicaid, the State Children's Health Insurance Program (SCHIP), insurance regulation functions, survey and certification, and the Clinical Laboratory Improvement Amendments (CLIA).

CMS Mission
The new name also reflects the scope of the Agency's mission - to assure healthcare security for Medicare and Medicaid beneficiaries.

CMS Vision
In serving beneficiaries, CMS will open its programs to full partnership with the entire health community to improve quality and efficiency in an evolving healthcare system.

CMS Goals
The Agency's goals are to:

- Protect and improve beneficiary health and satisfaction;
- Promote appropriate and predictable payments and high quality care;
- Promote understanding of CMS programs among beneficiaries, the healthcare community, and the public;
- Foster excellence in the design and administration of CMS programs; and
- Provide leadership in the broader healthcare marketplace to improve health.

To support the mission, vision, and goals of the Agency, CMS launched the following website in September 2001:

http://www.cms.hhs.gov/

This website is a valuable resource that provides information for the healthcare community on the Agency's programs, initiatives, and priorities.

DISCLAIMER

This guide addresses the submission of Medicare Part B claims by physicians and suppliers. For the purposes of this guide, references to the term "provider" generally apply to all physicians or suppliers, unless otherwise specified.

PREFACE

What Is a Part A Medicare Provider?

Medicare defines Part B providers as physicians and suppliers. Part A providers are institutions, including hospitals, Skilled Nursing Facilities (SNFs), home health agencies, comprehensive outpatient rehabilitation facilities, and others. Although Part A providers bill for Part B services in some situations, their specific billing procedures differ from those of physicians and suppliers, and therefore will not be discussed within this guide.

What Information is Included within this Guide?

This guide contains a variety of information to help billers submit accurate and timely Medicare claims. While providing historical and background information on Medicare Part A and Medicare Advantage, this guide is focused on providing information and procedures for physicians and suppliers to submit Medicare Part B claims. It is divided into the following sections and contains reference sections at the end of the guide.

Section 1.0 - Introduction to Medicare

Provides an overview of the Medicare Program, describing what it is, who manages and administers the program, eligibility requirements, and coverage requirements.

Section 2.0 - Becoming a Medicare Provider

Provides an introduction to the general rules for participating as a Medicare provider. It explains the types of providers, instructions for enrollment and updating provider information, common enrollment questions and answers, and information regarding reimbursement.

Section 3.0 - Submitting Medicare Claims

Provides an overview of how to submit both an electronic or a paper Medicare claim, how a provider can or cannot accept assignment, how to submit assigned and non-assigned claims, and Medicare Secondary Payer (MSP) submission regulations.

Section 4.0 - Protecting Medicare from Fraud and Abuse

Provides an overview of the Medical Review (MR) process, the Progressive Corrective Action (PCA) process, and ways to identify and prevent Medicare fraud and abuse.

Section 5.0 - Troubleshooting Denials and Claim Rejections

Explains numerous billing and data entry errors and provides methods for a provider to avoid such errors and submit Medicare claims accurately to avoid denied claims.

Section 6.0 - Introduction to HIPAA

Provides an overview of the Health Insurance Portability and Accountability Act (HIPAA) that protects

health insurance coverage for workers and their families, establishes national standards for electronic healthcare transactions, and protects security and privacy of health data.

Reference A - Provider Specialty Codes
Contains a list of physician and supplier specialties and their related codes.

Reference B - Form CMS-1500
Contains a template of the Part B claim form submitted to carriers and instructions for completing the form.

Reference C - Form CMS-1500 Electronic Claim Format Item Crosswalk
Contains a crosswalk that matches Form CMS-1500 paper claim items to the corresponding electronic claim fields.

Reference D - Beneficiary Admission Questionnaire
Contains questions that the provider should ask Medicare beneficiaries upon each inpatient and outpatient admission.

Reference E - Place of Service Codes
Contains a list of Place of Service (POS) and their related codes used on claims submission forms.

Reference F - Health Care Claim Adjustment Reason Codes
Contains a list of healthcare claim adjustment reason codes used on claims adjustment forms.

Reference G - Remittance Advice Remark Codes
Contains a list of remittance advice remark codes used on Remittance Notices.

Reference H - Glossary
Contains a list of terms used throughout this document.

Reference I - Acronyms
Contains a list of acronyms used throughout this document.

Reference J - Websites and Phone Numbers
Contains a list of websites and phone numbers that are referenced throughout this document.

Typeface	Example
Default	This is text in default format.
Italic	*This text is emphasized in italic format.*
bold	**This text is emphasized in bold format.**
bold italic	***This text is emphasized in bold italic format.***
BOLD CAPS	**THIS TEXT IS EMPHASIZED IN BOLD CAPS**
ITALIC CAPS	*THIS TEXT IS EMPHASIZED IN ITALIC CAPS*

The typeface conventions used for the text contained within this document are listed below:

Heading Style	Example
HEADING 1 STYLE	18pt AGaramond Bold, Caps, Centered, Blue
HEADING 2 STYLE	14pt AGaramond, Caps, Centered, Blue (85%)
HEADING 3 STYLE	12pt AGaramond, Bold, Caps, Centered, Blue (75%)
Heading 4 Style	12pt AGaramond, Bold, Centered, Black
Heading 5 Style	12pt AGaramond, Bold, Italics, Centered, Black

Information is organized and presented using the hierarchy of headings that are listed below: